

10632

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH a. COUNTY <b>Queen Anne Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md.</b> b. COUNTY <b>Queen Anne Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centerville, Md. R.F.D.</b>	
c. LENGTH OF STAY IN 1b <b>full life</b>		d. STREET ADDRESS <b>R.F.D.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sadie R. Arrington</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>II</b> Year <b>1956</b>	
5. SEX <b>fem.</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1879</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>10</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas F. Shertall</b>		14. MOTHER'S MAIDEN NAME <b>Rosalee Daughtery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>W. Walter Arrington</b>		Address <b>Centerville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Interstitial nephritis</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Heart Complication</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/15</b> 19 <b>56</b> , to <b>10/11</b> 19 <b>56</b> , that I last saw the deceased alive on <b>10/11</b> 19 <b>56</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Centerville, Md</b> DATE SIGNED <b>10/13/56</b>			
ACTUAL SIGNATURE <b>W. Henry Fisher</b>		M.D. <b>Centerville, Md</b>	
PHYSICIAN'S NAME (Type) <b></b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>Oct. 15, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's R.C. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>near Centerville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Williams</b>		ADDRESS <b>Easton, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>10/15/56</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. M. Adridge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 8

OCT 18 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10633 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10632

Reg. Dist. No.

254

<b>1. PLACE OF DEATH</b> a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u> c. LENGTH OF STAY IN 1b <u>12 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HARVEY GUESSFORD COUNCIL</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Oct. 10 1956</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov-23-1879</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shipyard Foreman</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Richard Council</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Emma Guessford</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>221-01-0554A</u>				<b>17. INFORMANT</b> <u>Mrs. Bertha L. Jones</u> Address <u>10 Payson Ave. Catonsville Baltimore 28, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO <u>Found dead in his home - 2nd Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input type="checkbox"/> , <b>Inquiry</b> <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>W. H. Fisher</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>10/13-56</u>			
<b>22a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <u>Buried</u>				<b>22b. DATE THEREOF</b> <u>Oct 13-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Chesterfield</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Buttwell Maryland</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. E. Evans</u>						<b>ADDRESS</b> <u>Baltimore Md - 061</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DATE 22/1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Elaine Armstrong</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Oct. 10 1956

100-381819 76

BUREAU V. 2

OCT 22 1956

RECEIVED

Received by  
New York State Department of Health  
Oct 13 - 26 1956

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10633

10634

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Beauregard</u> Middle <u>Davis</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27-1861</u>	9. AGE (In years last birthday) yrs. <u>95</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Davis</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Voshell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Ben. Walters--Barclay, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Deletations</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>7</u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
				20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>56</u> , to <u>Oct 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.H. Metcalfe</u>				ADDRESS (Street, city or town, state) <u>Templeville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>C.H. Metcalfe</u>				DATE SIGNED <u>10/24/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 26</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Templeville</u>		22d. LOCATION (City, town, or county) (State) <u>Templeville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Kane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct. 24</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar H. Kane</u>			



CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MA

BUREAU V. 2

RECEIVED

Oct 28 1966

101

W. H. H. H. H.

General  
Central  
General  
General  
General

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10635

## CERTIFICATE OF DEATH

Reg. Dist. No.

10634251

202

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b>		c. LENGTH OF STAY IN 1b <b>Church Hill</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John F. Dodd</b>		4. DATE OF DEATH Month Day Year <b>October 3 19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22-1873</b>
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mark Dodd</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-12-4804</b>	
17. INFORMANT <b>Mrs. John Dodd, Church Hill, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia</b> <b>352x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>CH</b>		20f. (City or town) (County) (State) <b>CH</b>	
21. I certify that I attended the deceased from <b>10/3</b> , 19 <b>56</b> to <b>10/3</b> , <b>56</b> , that I last saw the deceased alive on <b>10/3</b> , 19 <b>56</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Robert W. Farr, M. D.</b>		DATE SIGNED <b>October 6, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 6</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill, Col.</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		ADDRESS <b>Church Hill, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct. 9-56</b>		24b. REGISTRAR'S SIGNATURE <b>Edgar L. Lane</b>	

CERTIFICATE OF DEATH

BUREAU V. 3

OCT 11 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10636

### CERTIFICATE OF DEATH

10635

Reg. Dist. No. 253

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edmon</b> Last <b>Larrimore</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 1-1877</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farm Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward J. Larrimore</b>		14. MOTHER'S MAIDEN NAME <b>Annie Costin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elmer J. Larrimore-Church Hill, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of right lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 10, 1956</b> to <b>Oct 22, 1956</b> , that I last saw the deceased alive on <b>Oct 22, 1956</b> , and that death occurred at <b>2:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Devery Fisher</b>		ADDRESS (Street, city or town, state) <b>Centreville Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. Devery Fisher</b>		DATE SIGNED <b>10/24/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 25</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Centreville</b>	22d. LOCATION (City, town, or county) (State) <b>Centreville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar R. Kane</b>		ADDRESS <b>Church Hill, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct. 26</b>		24b. REGISTRAR'S SIGNATURE <b>Elyabeth Hester</b>	

# CERTIFICATE OF DEATH

100-58

1

OCT 30 1956

RECEIVED

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

VS AIS (4)  
 TSM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10637

## CERTIFICATE OF DEATH

10637

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Catherine</u> Last <u>Stutz</u>		4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 29, 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Enoch Clough</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Coleman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Elmer Larimore--Crumpton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>Chronic Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1, 1955</u> , 19 <u>  </u> , to <u>Oct 29, 1956</u> , that I last saw the deceased alive on <u>Oct 29, 1956</u> , and that death occurred at <u>10 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 1</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>	22d. LOCATION (City, town, or county) (State) <u>Crumpton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 2 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>

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NOV 2 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10638

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 10638  
 Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Queen Anne</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Croftsville</u>	LENGTH OF STAY (in this place) <u>See wife</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Croftsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Robert</u> (Middle) <u>S</u> (Last) <u>Teat</u>		(Month) <u>Oct</u> (Day) <u>21</u> (Year) <u>1954</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH: <u>Nov 9 - 1910</u>
9. AGE last birthday: <u>45</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Day work</u>	
11. BIRTHPLACE (State or foreign country): <u>Croftsville MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Steve Teat</u>		14. MOTHER'S MAIDEN NAME: <u>Blanche Gibbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>213-14-1486</u>	
17. INFORMANT & ADDRESS: <u>Pearl Thompson (sister) 2215 Saybert Rd. Pk 24</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>2520</u> Immediate cause (a) <u>Died in an Epileptic seizure</u> DUE TO Antecedent cause(s) (b) <u></u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. Henry Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/22/54</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>	DATE THEREOF: <u>Oct 24 1954</u>	NAME OF CEMETERY OR CREMATORY: <u>Croftsville Cemetery</u>	LOCATION (City, town, or county) (State): <u>Croftsville, Maryland</u>
DATE REC'D BY LOCAL REG. <u>10-24-54</u>	REGISTRAR'S SIGNATURE: <u>Elmer C. Crenshaw</u>	24. FUNERAL DIRECTOR: <u>James H. Burton</u> ADDRESS: <u>Croftsville, Md.</u>	



BUREAU V. S.

1921

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 10639  
 CERTIFICATE OF DEATH

10639

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCH HILL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCH HILL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>HENRY</u> Middle <u>THOMPSON</u> Last				4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-18-1918</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. CANNON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>MR. JAMES THOMPSON - CHURCH HILL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arterial Sclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Long standing results of gonorrhea &amp; syphilis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 17</u> , 19 <u>56</u> , to <u>Oct 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 17</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Metcalfe</u> M.D.				ADDRESS (Street, city or town, state) <u>Sunderland, Maryland</u> DATE SIGNED <u>10/20/56</u>			
PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>Oct. 20</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunderland</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10-20</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

CERTIFICATE OF DEATH

Central Hospital  
Central Hospital  
Central Hospital

Central Hospital  
Central Hospital  
Central Hospital

REAU V. 3

OCT 24 1956

RECEIVED



CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. R.

OCT 22 1956

RECEIVED

10-15-56 11:15 AM

RECEIVED  
BUREAU OF VITAL STATISTICS  
U.S. DEPARTMENT OF HEALTH